MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION
3315 West Truman Blvd., P.O. Box 58
Jefferson City, MO 65102-0058

INJURY NUMBER

SUBSTITUTION OF COUNSEL

_____ - _____

_____,)
Employee)
)
vs.)
)
_____,)
Employer)
)
and)
)
_____,)
Insurer)
)
_____,)
Third Party Administrator

Date of Accident/
Occupational Disease: _____

SUBSTITUTION OF COUNSEL

On behalf of the ☐ Employee ☐ Employer/Insurer ☐ Third Party Administrator

COMES NOW, the undersigned attorneys and request substitution of counsel in the above case.

Respectfully Submitted,

Entering Firm/Attorney or Co-Counsel

Signature _____
Attorney Name _____
Law Firm _____
Address _____
Phone No. _____
Fax No. _____
Bar No. _____
E-mail Address _____

Withdrawing Firm/Attorney or Co-Counsel

Signature _____
Attorney Name _____
Law Firm _____
Address _____
Phone No. _____
Fax No. _____
Bar No. _____
E-mail Address _____

Comments/Statements: _____

CERTIFICATE OF SERVICE

I certify that a copy of this Substitution of Counsel was mailed or hand delivered to all parties of record, or if represented by an attorney, to their attorneys of record this _____ day of _____, 20____.

Attorney's Signature _____ Bar No. _____

Attorney's Name *(Printed)* _____ Date _____

Address *(if different than above)* _____

DIVISION USE ONLY

DATE STAMP